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THE PRIVATE PRACTITIONER AND THE HEALTH DEPARTMENT*

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IN any consideration of the economics of medical practice the problems resultant upon the growth of preventive medicine and of the social conscience cannot be ignored. These group themselves under three main heads: (1) control of communicable disease; (2) prevention of disease; and (3) care of the sick who are indigent or near indigent. The problem of the care of those who are able to pay low fees, or even in some cases full fees, obtrudes itself to some degree, especially in connection with certain activities of health departments and health centers.

SIGNIFICANCE OF DISEASE PREVENTION EFFORTS

The movement aimed at prevention of all disease is a logical outgrowth of the effort to *prevent* communicable disease, which in turn developed from the attempt to *control* communicable disease. Control is obviously a problem having to do with the public en masse, and is primarily the problem of the public health department. Prevention involves many matters which can be handled only by the public health department, such as inspection of water supplies, of food supplies, of methods of sewage and garbage disposal, of quarantine, etc. It has to do with the public as a whole, and cannot be handled as it affects individuals. However much credit belongs to the medical profession for demonstrating the necessity and efficiency of these measures, there can be no question of conflict with the individual medical practitioner in their enforcement.

PREVENTION OF COMMUNICABLE DISEASES

Science has made available additional means for the prevention of communicable diseases, perhaps the most notable being immunization against smallpox and diphtheria. Smallpox is now, thanks to the general use of vaccine along with improved sanitation and the quarantine of all cases, largely a disease of the past. Immunization against diphtheria is of much more recent origin, but a great decline in incidence has taken place within the past generation. The demonstration of the contagiousness of tuberculosis gave a tremendous impetus to attempts not only to cure but prevent it, and in 1904 led to the founding of the National Association for the Study and Prevention of Tuberculosis. The aggressive attacks on the disease from numerous angles have been productive of greater results than many of the most optimistic members of that organization even hoped for. The great increase in the degenerative diseases as a cause of death has more recently focused attention upon them, and increasing effort is being expended to prevent the development of these noncommunicable diseases.

FIELDS OF PRIVATE AND PUBLIC PRACTICE

The treatment of disease was formerly the field of the private practitioner exclusively, with the exception of the provision made by the state or community for the care of those financially unable to meet the problems of illness, as a result of which we have today in all large centers the development of great institutions for the indigent sick. In practically every case skilled medical care is being provided by the private practitioner "without money and without price."

As the public health administrator has viewed the vast and constantly expanding horizon of preventive medicine, he has enthusiastically enlarged the facilities of his departments to include a greater and greater field of activity. This has given rise to a situation without precedent, and the time has come when it is necessary to take stock; to ask ourselves whether the expansion is justified from the standpoint of the general public and the medical profession as a whole.

There is a legitimate field of activity for both the health department and the private practitioner, but when we attempt to delimit these fields we at once find ourselves dealing with a situation of great complexity. There has been presented to this convention a carefully thought-out report on this subject which cannot fail to meet with the approval of all thoughtful members.

In the presence of a smallpox epidemic we would be the last to question the propriety of the

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health department doing all in its power to secure immunization of the entire public in the shortest possible time, irrespective of economic status. At other times the private physician should see to it that his clientele are adequately protected. The more conscientiously this is done the less the danger of an epidemic, and the less work there will be for the health department should an epidemic occur.

Large epidemics of diphtheria rarely occur now, and those of us whose practice does not include a large proportion of children come into contact with the disease so seldom that we are prone to minimize its importance. Its still high mortality rate and the fact that it is always with us should prompt a greater utilization of our opportunity to immunize the children of our patients. The occurrence of small outbreaks in the schools means necessarily the immediate immunization of fairly large groups of children. This is usually done by the health department as an emergency measure, again irrespective of economic status. Its necessity is in inverse proportion to the thoroughness with which the private practitioner has attended to it in advance.

HEALTH CENTERS

For the purpose of centralizing and increasing the efficiency of the health department activities, we have seen during the past decade the development of health centers. A health center has been defined as "an organization which provides, promotes and coördinates medical service and related social service for a specified district."[1] This is an all-inclusive definition, but for the purposes of this paper the statement concerning the aims of the organization of the Alameda County Health Center is more to the point: "to increase the efficiency of public health, relief, and welfare work in Alameda; to eliminate, by consolidation and coöperation, duplications of effort; to maintain clinics and furnish medical treatment and advice for persons unable to pay; to disseminate knowledge of, and to educate the public in, preventive medicine; to coöperate with the Health Department of Alameda, the Public Health Center of Alameda County, and other institutions and agencies of like character."

In the counties of Alameda, San Joaquin, and Los Angeles the centers have reached a high degree of development; there are nine in Los Angeles County and some twenty smaller centers in rented quarters; this county's centers have been maintained with medical staffs in part salaried and in part volunteer; they have served in regard to communicable disease control and the various welfare and educational activities, and have also rendered diagnostic and therapeutic services to the indigent and semi-indigent. Noteworthy development has taken place in several other states, particularly New York, Massachusetts, Connecticut, Ohio, and Iowa.

Time will not permit of a detailed study of the various health center plans and their functioning, and the advantages and disadvantages of the different types. Many committees have devoted much time and thought to this problem, and in the present fluid state of society and of the problems connected with illness, dogmatism is dangerous.

PART OF MEDICAL PROFESSION IN PUBLIC HEALTH PROGRAMS

But it is evident that the private practitioner should play a much more important part in all public health programs than in the past. As private practitioners we have recognized the great advance in public health and preventive medicine, but have tended to leave that type of work largely or entirely to specialists, with the result that frequently the specialists have developed it without our active assistance. This has not been to the best interests of either. The health administrators have felt that the general profession did not appreciate their efforts; and, as the need and opportunity for their work have increased wherever preventive medicine has opened new vistas, there has been a tendency to impatience with the conservatism and lack of interest manifested by the private practitioner. Lacking the stabilizing influence of his coöperation, some ambitious health projects, highly laudable in themselves, have been launched, when a more careful consideration of all the social elements involved and closer coördination with the medical profession as a whole would have suggested much less radical and expensive programs. These would, in the long run, have been at least as productive of results, and much friction and turmoil would have been avoided, to say nothing of the burden placed upon the taxpayer by the construction and equipping of buildings far in advance of the needs of the community. The general profession has felt that in some cases the health department activities have tended to encroach steadily upon the field of private practice and to lead strongly in the direction of state medicine.

TAXPAYERS SHOULD ALSO BE CONSIDERED

The present depression has brought home to us the fact that the almost unlimited expenditures of the past few years on our charitable and semicharitable institutions were based on a false premise. "The best is none too good" for our unfortunate improvident citizens may be beautiful sentiment, but "as good as is reasonable under the circumstances" would appear to be more practical. It seems probable that the tax-paying public and those having control of the taxpayers' money will be governed more by this latter idea in the near future. Health centers represent a very considerable capital outlay and a heavy maintenance cost. They should be built only after a careful study of the needs of the people to be served and the approval of the medical society.

HEALTH CENTER ACTIVITIES

Health-center activities may be divided into two classes: those belonging strictly to the public health department, and those having to do with the indigent sick of the community. Under the former head would be classed inspection services connected with food supplies, water, sanitation, quarantine, vital statistics, health education, etc.; under

1 Davis, Michael M.: Clinics, Hospitals, and Health Centers, Harper's, 1927.

the latter the general medical and surgical clinic with subdivisions for the specialties. Prenatal and well-baby clinics probably have a place under the health department, but any individual requiring treatment should be referred to the private physician, or, if indigent, to the other clinic. Diagnostic and therapeutic services are for those who cannot compensate the physician for such work. There is no justification for the use of public funds to supply such services to those able to pay. Tuberculosis and venereal clinics entail special problems, but probably belong in the clinical department.

"In all free health centers there should be a well-conducted social service department, first, to guarantee to the public, to the physicians, and to those who supply the money and the service that only applicants who are unable to pay for private service are admitted; second, after a patient is admitted, to see that the recommendations made by the doctor are followed out as thoroughly and expeditiously as possible, so that the greatest benefit will be secured from his services." [2] It is obvious that the relationship between the clinic and the medical profession hinges largely on the efficiency of the social service department; for, unless there be adequate studies of all applicants, abuses will inevitably creep in and lead to friction.

The clinical department should be composed of members of the local medical association. They should form a staff organization to manage it. Where a number of health centers or clinics exist under one health or charities department, there should be a central organization of the volunteer staffs of such clinics, and within it a central governing committee. We are strongly of the opinion that there should be active supervision and coöperation on the part of the local medical society; it is imperative where the centers cover any large part of a county, in which case the county medical association should be vitally interested. The volunteer staffs and the local or county medical association should be represented on the supervising body if the clinics are to function to their highest efficiency in coöperation with the department of county charities, the county hospital, the county health department, and the medical profession.

The health-center laboratory and diagnostic facilities could be of increased service to the community if they were made available to the local physicians for such of their patients as require work of this type but are unable to pay anything approximating the regular fees. The same use might be made of some of the expensive physiotherapeutic appliances already installed.

LIMITATIONS IN PUBLIC HEALTH WORK

The extension of public health activities to include all the possible range of effort in the field of preventive medicine is stimulating to contemplate in the abstract, but might well be a nightmare to the taxpayer if considered as an immediately legitimate undertaking. The periodic health examination of all the citizens of the community would be a most praiseworthy procedure, undoubtedly productive of appreciable improvement in the health of the community; but not even the members of the medical profession are as yet sufficiently impressed with its possibilities to have attempted it as a practicable procedure for themselves, to say nothing of their patients. Its more enthusiastic advocates, both medical and nonmedical, are prone to lose sight of the fact that our knowledge of the beginnings of most of the diseases against which public effort is aimed is still far from complete, and that utilization of what little knowledge we possess for the detection of these diseases in their incipiency is one of the most difficult technical procedures in medicine, calling for the highest degree of skill and the outlay of a very considerable amount in money for each patient. When done in a routine manner it is apt to mislead and give rise to a sense of security which rests on a very uncertain foundation. The ultimate result would, I fear, be a reaction to the discredit of the medical profession.

That all who are not in good health, rich and poor alike, should have a complete examination and diagnostic study when they present themselves to the doctor or to the clinic, is a praiseworthy ideal. But the cost of such service, undertaken by the community, would be prohibitive, and the service would in no way be commensurate with the expense.

POSSIBILITIES

In all communities, large and small, the private practitioners should be thoroughly familiar with all public health measures and activities. The health department owes a duty to the medical profession second only to that which it owes the general public. It is its opportunity and should be its privilege to educate the general profession in public health measures to the end that every physician's office may be a health center. "Fundamentally the problem is one of preparing the public for the service which may be rendered by the physician and at the same time preparing the physician to give the type of service to which the public is entitled." [3] This would entail much work and considerable expense, but the results would amply justify the cost.

The recent experience of Geib and Vaughan in Detroit in connection with diphtheria immunization has demonstrated this beautifully. It is true that the cost was considerably in excess of what it would have been had the health department handled it in the usual manner, but a much higher percentage of the susceptible population was immunized than would have been possible had that been done. It was the conviction of the health department also that the additional expense was amply justified as a public health educational measure. A step in the same direction has recently been made by the Los Angeles County Medical Association with the coöperation of the various health officers in the county.

The measure of the success and efficiency of a health officer should be, not the territory covered

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2 Report on Health Centers of Alameda County.

3 Geib and Vaughan: The Physician as Health Worker, Jour. A. M. A., Vol. xcvii, No. 6, p. 366.

or the number of employees or health centers in his department, but the extent to which he has merited the confidence of and popularized health measures with the general medical profession, because this will in turn be an index of the thoroughness with which health education has reached and permeated the rank and file of the general public. It is not to be doubted that the contacts of the medical profession as a whole far exceed those of the health department. An attitude of mutual coöperation and helpfulness on the part of the health department and the private practitioner will result in increased efficiency and much more general adoption of public health measures, and will enable the practitioner to serve his patients better and to increase the scope of his activities.

Our American system of government is based on the theory that the safest and best plan is to have the people do as much for themselves as possible. This may entail more initial expense than would centralized governmental action, but it is cheaper in the long run.

CHARITY HOSPITALS AND CLINICS

Reference has been made to the services rendered without compensation by the private practitioners in the care of the indigent in community hospitals. It is true that the physician derives valuable experience from the work he does at these institutions. It is equally true that in no other business or profession does the individual donate his services simply for the experience he gains, however valuable that may be. It has been charged that physicians take positions on the staff of these hospitals because of the practice they get indirectly through the patients there. As a faithful and regular worker in our own county hospital for well over a decade, I have yet to see sufficient benefit of this type to pay the automobile expense incidental to service there. I can call to mind several items on the wrong side of the ledger in connection wtih such patients. My experience in this is the same as that of practically all members of the attending staff of that institution.

Charitable clinics without number abound in our State, particularly in the southland, in many cases filling a definite need, in others serving only as an outlet for the energies and philanthropic dispositions of worthy but not always well advised citizens. Frequently the efforts of deserving institutions are duplicated, in consequence of which they are forced to labor under a heavy handicap. Such duplication inevitably results in inefficiency and excessive costs of administration. Irrespective of the need for the clinic and the amount of money expended on it, free service is expected and often demanded of the physicians of the community. It is seldom, indeed, that they are permitted a voice in determining the policies of the clinic. As your Committee on Hospitals, Clinics, and Dispensaries reported last night, there is need for legal measures which will place all such groups under the control of a central organization, probably the health department, which would set up standards such as have been approved by this association, and see that they were lived up to.

Apart from the general idea held by the public that the doctor makes his money easily and in large amounts, and the tradition among the members of the profession that ours is primarily a humanitarian vocation, there is no reason why the community should expect us to render gratuitously professional services worth in the aggregate, throughout the State, millions of dollars a year. Do the administrative or political powers think any more of us for it?

The organizations served by the Community Chest, which are the reason for its coming into being, exist by virtue of the physicians' gratuitous services. I venture the opinion that these services to charitable institutions are comparable in value to the contributions made by all other groups of citizens combined. In the annual Chest budget, do we receive credit for their value? Is the doctor consulted in regard to policies? Is his opinion asked or considered relative to the standing of the various organizations and their merits? We are perhaps not wholly free of blame for our present situation, but the fact remains that we are going to be "less than the dust" until we assert ourselves.

IN CONCLUSION

We do not know what lies ahead of us. We have had an intimation of the character of the final recommendation of the Committee on the Costs of Medical Care. We hear rumors of radical political action. Whatever eventuates, we must be prepared to see to it that nothing is done, under the guise of benevolent paternalism, which will throttle medical initiative and progress, with resultant deterioration in the quality of service received by the people. We must also see to it that if provision be made by the state for the extension of medical and hospital care for its citizens, cognizance be taken of the services rendered by the physician in hospital, health center, and clinic, at present uncompensated, and that nothing be done to limit the patient's freedom of choice in the selection of his physician.

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DISCUSSION

JOHN C. RUDDOCK, M. D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Howson's paper comes at a time when the medical profession is awakening to a realization that there are certain encroachments which have come insidiously, and which may, unless curbed or regulated, destroy a relationship between the doctor and his patient, which has always been an individual one.

Doctor Howson's paper has taken up merely one phase of the problem of this metamorphosis that is occurring—that phase dealing with public health. The medical profession itself is responsible for public health and, as has been so well brought out by the speaker, there has been a gradual usurping and overlapping between the scope of practice of the health officer and the private practitioner because of the enlargement of the health departments in those communities which are more thickly populated.

In the beginning, when by means of organized effort it was proved that the incidence and mortality rate of certain diseases could be lowered, the health department was the answer, introduced by the medical profession in order to educate the public, improve the hygiene of the community, quarantine communicable diseases, encourage vaccination and immunization, and

keep certain vital records; and through this means decrease disease in the community and safeguard the public.

There have been from time to time many added detailed duties which various health departments have usurped and which often may have a public health factor in a very broad sense. Some of these are not real public health issues, but social problems and maladjustments.

To strictly draw a line of demarcation between the practice of medicine by a governmental agency, as represented in this instance by the public health departments, and private practice is almost impossible. The indigent, we all agree, are a problem that faces the community as a whole; but if Mr. X, who is not an indigent, has a mitral stenosis it is a problem that belongs strictly to Mr. X, and does not concern the community as a whole. The treatment of disease in those classes that are nonindigent rightfully belongs to and is the business of the patient and his doctor.

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H. M. Bracken, M.D. (Retired State Health Officer, Minnesota, 1897-1919, Claremont).—This is a timely paper. One important question is, should a health center care for the indigent sick? I think not. It is a dangerous procedure to combine under the same roof health problems and clinical problems. The diagnostic and therapeutic services for the indigent should be carried out under hospital supervision through the outdoor department or the hospital itself, rather than under the health department. A health center should give its attention to the prevention of disease, not to its treatment.

The health center does not need a social service department. The hospital does; and for a dual purpose. First, to see that only the indigent are cared for at public expense. Second, to see that those who need follow up treatment report for such as directed. This latter applies especially to the treatment of venereal diseases.

There may be districts in which there are no hospitals where the ambulant indigents can be cared for. Under such conditions it may be necessary to have an "outdoor department" for the sick at a health center. It is unusual, however, to find a health center in a district where a hospital is not easily accessible. If an outdoor department is to be operated as a health center it should be as a distinct unit under a group of trained medical men, including the specialists. The county medical society should be thoroughly interested in the make-up of this staff. The health activities at such a center should be carried on by a staff of thoroughly trained health agents.

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John H. Graves, M. D. (977 Valencia Street, San Francisco).—Doctor Howson's paper indicates a thorough knowledge of the subject and makes it possible for him to deal with the various phases of the problem with entire fairness.

There is a legitimate field of activity for the health officers of federal, state, and local health departments, and the splendid results of their work must be obvious to the most casual observer. It is unfortunate that in certain instances the bureaucratic spirit is evidenced by a tendency to transgress on territory and engage in activities which clearly belong to curative medicine. Speaking for the State Department of Public Health, the controlling board of which is composed of officers and members of this Association, it is almost unnecessary to say that the State Department of Public Health is distinctly against the invasion of the legitimate field of the practicing physician by the health officers under its control.

It is true that the line which divides the fields of public health activity and the physician's practice is, in places, ill-defined and scarcely perceptible. It is, and will be, the policy of the State Board of Health to make this dividing line as clear and distinct as possible.

It is the Board's purpose to secure friendly and harmonious coöperation of all the forces and agencies interested in the prevention and cure of disease so that a more efficient service will be rendered. The physicians must accept the responsibility for, and make a practice of, immunization of children under school age. Some of the heaviest onslaughts of diphtheria occur before the age of six or seven years, and the State Board is developing a program with the physicians of the State, through the county societies, by which the family physician will, at a proper time, send a card of notification to the parents that the child should be immunized. The Board believes that the great majority of parents will heed this advice and that the physicians are perfectly willing to perform the immunization on the same basis that they render other professional service to their patients. We hope to furnish duplicate cards which will be forwarded the health department and will give statistical evidence of the number of children who have been immunized. These figures, compared with the birth statistics, will give an excellent estimate of the number who have not been immunized.

Intelligent effort along similar lines will unquestionably greatly increase protection to childhood, lessen the work of the health officer, and add to the practice of the physician.

An intelligent appreciation of the problem on the part of all, a little more of harmonious coöperation, and a little less of caustic comment, will unquestionably go far toward solving the problem.

PERINEPHRITIS—SUPPURATIVE AND NONSUPPURATIVE*

By Charles Pierre Mathé, M. D.
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Discussion *by George F. Schenck, M. D., Los Angeles; Robert V. Day, M. D., Los Angeles; Frank Hinman, M. D., San Francisco.*

INFECTION of the perinephritic tissues is of great interest to all studying kidney diseases because of extreme difficulty in diagnosis resulting from meager clinical signs, obscure symptoms, and lack of urinary disturbances. Perinephritis is a term applied to inflammation of the cellulo-adipose tissue surrounding the kidney and includes the renal capsule. In Germany the term "perinephritis" is limited to inflammatory processes of the kidney capsule, and the name "paranephritis" is applied to those involving the perirenal fat. These distinguishing terms, however, have not been generally adopted. The type of acute perinephritis which is secondary to inflammatory conditions of the kidney, such as nephritis, cortical abscess formation, tuberculosis, nephrolithiasis, etc., is often unrecognized on account of being overshadowed by the pathological findings presented by the kidney itself. Likewise, primary perinephritis is unrecognized because the adjacent healthy kidney causes no symptoms and fails to reveal any pathologic findings in making a urological examination. Primary and secondary suppurative conditions of the perirenal tissues, commonly known as perinephritic abscess, also present a difficult problem of differential diagnosis; yet treatment of these conditions, in order to be efficacious, must be instituted early. In making routine autopsies, I have been impressed by the frequency of perinephritis which had, in many instances, entirely escaped the attention of the attending physician. In the course of making surgical inter-

* From the department of urology, Saint Mary's Hospital and Southern Pacific Hospital.

* Read before the Urology Section of the California Medical Association at the sixty-first annual session, Pasadena, May 2–5, 1932.